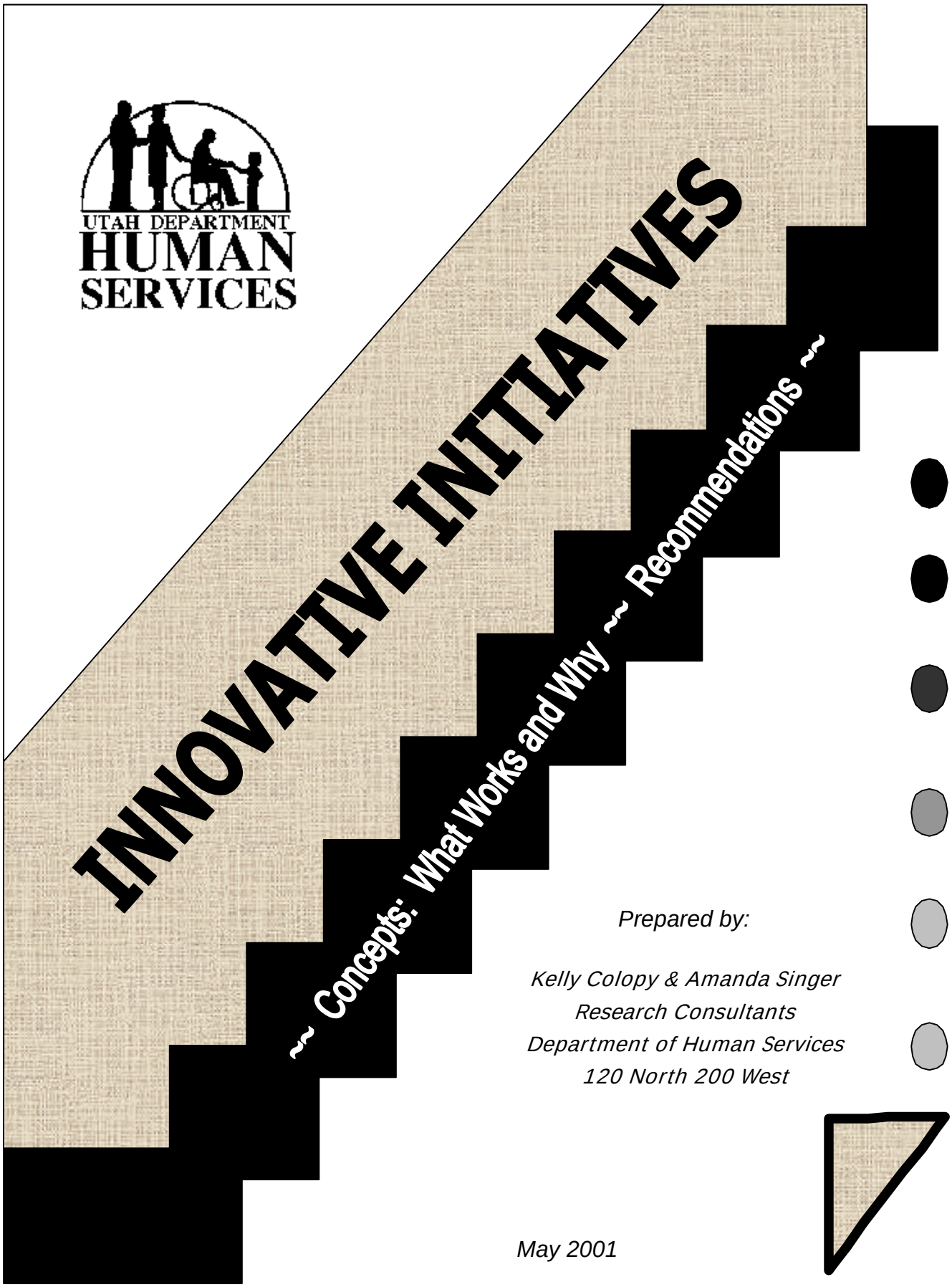

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May 2001

ACKNOWLEDGEMENTS

We would like to thank the following people in the regions for spending extended time with us to describe their initiatives and explain why they felt these initiatives were so important. Their enthusiasm was inspiring. They are truly the champions/cheerleaders that are changing the way the Department and its divisions reach children, youth, and adults.

Matthew Denhalter
Monica Hullinger
Tracey Johnson
Judge Kay Lindsey
McCord Marshall
Randy Soderquist
Jackie Southwick
Stephanie Strohl
Barbara Stubbs
Paul Thorpe
Nancy Zelenack

We would also like to thank our contacts at the division administrative level for talking with us about the division programs and guiding us to the interesting and innovative initiatives. Their support of these initiatives allows those at the local levels to make these initiatives successful.

Richard Anderson
Blake Chard
Patrick Fleming
Sue Geary
Helen Goddard
Michelle Jenson
Dan Maldonado
Ron Stromberg
Mary Ann Williams
Denise Winslow

The interviews conducted for this paper were a wonderful learning opportunity for us. So many interesting things are going on across the Department. We hope this paper is effective in sharing the highlights of these selected initiatives and portraying the enthusiasm of those we interviewed.

INTRODUCTION

PURPOSE

This paper is designed to discuss innovative initiatives that are currently underway in the Department, share the important concepts behind these initiatives—what works and why--and provide recommendations that foster discussion around how these concepts could be implemented more broadly across the Department.

METHODOLOGY

Each division director and a number of staff members were approached to discuss their innovative programs for serving clients and to determine where these programs were most effective. At that time, names were gathered for follow-up interviews and, in some cases, visits. The study team conducted interviews with representatives from each initiative during a two-month period. Respondents were asked to discuss their initiative and why they felt the initiative was an effective mechanism for serving clients. The results of these interviews are presented in this paper. The following initiatives were reviewed:

- Practice Model (DCFS)
- Wraparound (DMH Frontiers Grant)
- Self Determination Initiative (DSPD)
- Dependency Court (DCFS, DSA)
- Archway (DYC)
- Multidisciplinary Teams (DAAS-APS)

FORMAT

This report begins with the study findings then makes recommendations regarding steps the Department could take to improve how it, and its divisions, conducts business and serves its clients.

It's NOT the way we've always done it: SAME WORDS--NEW WAY OF SERVING CLIENTS

Since the mid-1980s, the divisions in the Department have strived to develop successful programs that include concepts such as family involvement, client-centered planning, strengths-based, community-based, and collaboration. The new initiatives discussed in this paper have taken these basic concepts and moved beyond their standard definitions. They agree they are using the same words but they are doing them very differently—they have changed the way they serve clients. However, in many places, it has been a struggle to implement the initiatives because many supervisors and front-line workers say, "We are already doing this," or "That's the way we've always done it and we are doing it now." The new initiatives are defining and operationalizing familiar concepts in new ways, and using different tools and techniques to improve the way they serve clients.

Each of the innovative initiatives reviewed has a set of guidelines or values that directs the delivery of services. Many of the components of these guidelines are similar regardless of the division and population served. The language is often different but the basic philosophies are the same. The common concepts that the innovative incentives share are outlined below.

COMMON THREADS - - THE CONCEPTS

CLIENT CENTERED – "WHAT DO YOU NEED?"

A service system that is driven by the needs of the client and their family is a core value that is universally accepted across agencies and divisions. A system that is client-centered means the needs of the client dictate the types and mix of services provided. The client-centered focus is seen as a commitment to adapt an array of services to the client. Even though this value is widely accepted among agencies, it is still often practiced in a manner that fits clients into pre-exiting and pre-determined sets of services. The caseworker identifies the services that are easily accessible and offers these to the client. For example, if the client has behavioral and emotional problems the client receives outpatient therapy; if the parent has poor parenting skills, the parent is referred to parenting classes. All clients with similar assessments receive the same services with little variation. These plans tend not to be effective in meeting the client's and family's needs that reach beyond available categorical services.

The innovative initiatives view "client centered" in a different manner. "Client centered" means that the client is asked to identify what they **need** to overcome their current situation and stay in their home and community. The question "What do you need?" does not automatically generate a list of specific readily available services like outpatient treatment or out of home care, but rather focuses the client and the worker on overcoming the barriers and situations they currently face. It builds services and supports "one client at a time." This approach has the advantage of respecting the clients wishes, maximizing the opportunities for the client to be involved in the planning and delivery of services, and increasing the client's commitment and acceptance of the services. The client and family have a strong and legitimate voice in all aspects of their services and support. The "What do you need?" question may appear to be a slight difference, but it results in a very different way of serving clients and developing services.

The service plan that is needs based, rather than service-based, may incorporate existing categorical services if appropriate to the needs of the client and family. But the plan will also combine traditional services with modified services, newly created services, informal supports, and community resources. In addition, the "What do you need?" approach focuses on multiple areas of the client's and family's life not just the obvious presenting problem. These areas may include living situation, financial, educational/vocational, social/recreational, psychological, health, legal, cultural, safety, and others.

FAMILY INVOLVEMENT

"Nothing about me without me"

For the innovative initiatives, family involvement means much more than including family members in the development of service plans and signing the plans. It means that clients and families are full and active partners in all aspects of service planning and decisions that affect them. They are present at discussions that relate to their plans, have an opportunity to voice their preferences, and to ultimately feel they own the plan. This "Nothing about me without me" approach is markedly different than what usually occurs when staff determine the services and then informs the family about the service plan.

Family is the expert

Family involvement also includes the notion that family members and clients know themselves better than professionals who may be strangers to the family. The families and clients know what they are willing and capable of undertaking, what will work for them, and they understand their strengths, abilities, and potential barriers. They also can identify and access their own informal supports better than professionals. Families are actively engaged in every aspect of planning, implementing, and evaluating their services and supports. In this approach the family and the client become the expert. The caseworker is not seen as the expert that can "fix" or rescue the family. The role of the caseworker becomes one of facilitating and accessing resources.

The family and client are also active participants in identifying and selecting the members of the service team. Ideally this team is composed of 50% of individuals from public and private agencies and 50% non-professionals the family selects.

Families as Participants in Program System Level Operations and Quality Improvement

The innovative initiatives understand that families, as consumers of services, have insights, ideas, and solutions that can be utilized to improve and enhance the quality of services. They actively involve families in planning and decision-making because it helps ensure that the design of programs and services offered actually meets family and community needs. The feedback from families is actively solicited and used to produce enduring changes to the organization and the services provided. Families and clients are offered training and given information that will support and encourage them to be effective participants, leaders, and informed decisionmakers.

Families and Clients as Advocates

Families and clients are recruited, trained, and paid to advocate on the behalf of individual clients. This family advocate role ensures clients and their families understand and receive the services they need. In addition, the development of local parent support and advocacy groups is supported and encouraged with funding, training, and technical assistance.

STRENGTHS-BASED

Many of the individuals we interviewed stated that moving to a **strengths-based** approach in dealing with clients and families, conducting assessments, and developing service plans was

the most difficult part of implementing and maintaining their initiatives. So ingrained is the deficit approach that it is a constant struggle to turn it around and use a strengths-based approach.

The strengths-based approach requires caseworkers to acknowledge that all clients and families are capable and have strengths. It mandates the use of non-judgmental, non-pathologizing, and non-blaming language in both written documentation and communications with clients and families. Caseworkers using this approach focus on strengths in order to learn about the client and family, get a balanced picture of the situation, and discover the resources the family has available. The identification of strengths is viewed as the most significant part of developing, resourcing, and supporting the service plan.

COMMUNITY-BASED AND INFORMAL SUPPORTS

The traditional view of community-based services tends to mean that services are not provided in an institution but are delivered in a less restrictive environment - the community. Community-based services for the innovative initiatives means a commitment to providing services in the community within which the client and family lives, works, and plays. This guideline uses out-of-area placements only to provide short-term services to stabilize the client, with the goal of returning the client to his/her home community. The challenge of this approach lies in providing services in areas of the state that have few services. Accessing and maximizing the use of informal family and community resources to meet the needs of the family and the client is what makes community based services a reality. The preferences, choices, values, and culture of the family and client--not what is administratively expedient or readily available--is the basis for developing informal supports.

The individuals we interviewed stated that developing community-based services and informal supports was very time consuming and involved accessing resources and individuals in the community that are not usually considered part of the standard array of services. Utilizing the expertise, persistence, and creativity of family members and staff with titles like service broker, community developer, and resource specialist was key to developing and accessing these services and supports.

ROLE OF CASEWORKER

Caseworkers in the innovative models have adopted new roles in working across agencies and systems, and with clients and families. These new roles include:

- shifting from a professionally-centered service model to a family-centered service model,
- shifting from the “professional as expert” to the “family as expert,”
- shifting to a model of professional as facilitator,
- shifting from prescribers of treatment to facilitators of family decisionmaking, and
- shifting from service strategies that attempt to fit families into available options to service strategies that blend informal and formal service support options to create plans individualized to the client and family specific needs.

SERVICE TEAM

The individuals involved and the manner in which a service team functions was different from the typical interagency team for several of the initiatives. The client and family (rather than agency staff) identifies all the resource people involved with the family, as well as individuals the family knows who have helped them in the past and are concerned about the client and family. The team involves the case manager, all family members, natural supports to the family (includes relatives, church members, friends), and professional staff involved with the client. The team may also include a family advocate if that is the family’s desire. The service team is not a group of professionals meeting to discuss cases, it is a team uniquely designed to meet the needs of an individual client and family.

The team works with the family to determine the client's and family's vision and needs, identify the needs and expectations of the team, develop strategies to meet all the needs, prioritize strategies, determine outcomes to be realized, establish a plan, and assign roles and tasks. The plan is disseminated to all individuals on the team. Team members are responsible to follow-up, complete the tasks assigned, and keep updated on the client's status.

TOOLS AND SKILLS

FACT was developed to enhance the provision of collaborative, community-based services for clients with complex needs. FACT brought people from different agencies together to determine the services a family needed and to provide these services, or funding for these services, to the family. However, at that time, no tools were available to facilitate the collaborative process, involve families, and access informal supports. Nationally, states and consultants have begun to develop skills and tools that can be used to ensure families get the resources and services they need in their communities. The initiatives reviewed in this paper have used a number of these tools and skills to improve services for clients with complex needs. These tools and skills include partnering and teaming; client-centered planning, budgeting, and outreach; wraparound service plans; and crisis and safety plans. (Refer to Appendixes I and II for complete descriptions and examples.)

It's NOT the way we've always done it: SAME WORDS--NEW WAY OF DOING BUSINESS

According to one respondent, "When I'm talking to others about doing this, I tell them that unless you are willing to change everything about the way you do business, don't bother." What makes these innovative initiatives effective is that staff have truly changed the way they operate.

Three key elements were evident in the initiatives we visited. The elements listed below, we feel, were inherent to the success of the initiatives.

INTEGRATION OF CORE VALUES

Where this "new way of doing business" is working, a set of core values has been developed to guide client services. However, use of these core values does not stop with client service, they are integrated into everything that takes place—the way they plan, allocate resources, conduct staff meetings, train staff, work with their boards, and approach people in the field. The principles are constantly and consistently modeled. They are using the same values and principles used when serving clients and applying them to the business side of what they do. For example, when using a strength-based approach, the approach is used not only with clients, but with staff and in planning. For the Division of Services for People with Disabilities, consumer/family-centered means families and consumers are involved in all aspects of the agency. The core values are integrated into the procedures, practices, and principles of the agency.

People involved with these initiatives say they moved to this "new way" because it was ineffective to separate how clients are served from how programs are administered. When the administrative operations are improved, services for clients improve. Many other efforts to serve clients are less effective because they are not truly integrated into the life of the agency—they are seen as separate "programs."

CHAMPIONS/CHEERLEADERS

People who are highly motivated and committed to the new practice are essential to the implementation. They constantly model, mentor, and reinforce the core values to their staff and others around them. They think creatively about how the values can be used and applied in different situations and how they can encourage others to move forward in their practice. In discussions with one "cheerleader," the person continually pointed out to us that she had just used a practice principle and outlined how these principles could be used in any situation. Without these "cheerleaders," reform efforts tend to stall because they are seen as programs separate from the regular way of doing business. We found these cheerleaders at two levels—regional directors and supervisors. While most of the direct staff motivation, modeling, and mentoring came from the supervisors, the regional directors for those services were very important. They not only understood this new thinking and were completely supportive, but also led the charge for change. This leadership is important to the implementation because all staff levels—supervisors to front-line workers—feel supported. Supervisors talked about the importance of this support in maintaining their enthusiasm and their ability to overcome obstacles.

CONTINUOUS TRAINING AND FOLLOW-UP

Training comes in two forms. The first are training events that provide information, background, skills, and hands-on opportunities to staff members on the core values and concepts they are expected to use. The second focuses on continually reinforcing and expanding staffs' skill base. This reinforcement enables staff to make the necessary, significant, changes to the way they practice. Training is continuously provided and reinforced through staff meetings and modeling. For example, in one DCFS region, the supervisor developed laminated cards for each staff member with a Practice Model principle on the front and components of the principle on the back. The supervisor continually encourages staff members to carry these cards so they can review them prior to visiting a client to ensure they can apply the principles, and to review them after the visit to determine whether the principle was applied appropriately. This supervisor also includes a component of Practice Model training in nearly all her staff meetings. She introduces a principle and asks each staff member to provide an example of how they used this principle in their work. This supervisor also constantly models the principles with her staff through her interaction with staff because she believes their interaction with clients is affected by their interaction with her and other staff members. Another supervisor, when staff members indicate they do not see the benefits of the Practice Model concepts, accompanies individual staff members on client visits to model the new practice and then discuss its applications. These supervisors are constantly recognizing and rewarding their staff members when they use the Practice Model principles.

OTHER ISSUES

While interviewing administrators and supervisors, we were surprised to receive unsolicited information about topics that did not tie directly to our mission of exploring innovative initiatives. These included comments about the frustration of serving clients with complex needs who do not fit into division mandates, and feedback regarding the lack of cooperation with other divisions within the Department. These issues will be presented for possible further discussion without outlining recommendations for resolution.

CLIENTS WITH COMPLEX NEEDS

In spite of the innovative initiatives, agencies continue to struggle with serving clients whose conditions do not meet individual agency mandates. These include, to name just a few, clients with traumatic brain injury, organic brain syndrome, borderline mental retardation with severe behavior disorders, and non-adjudicated sexual offending youth. Agencies are reluctant or refuse to provide services for a number of reasons including, they are afraid these clients will "break the bank," the agency does not have the expertise to serve the client, and/or an available set of services does not exist to meet the client's complex needs. The agencies are also afraid that if they accept the client they will be solely responsible for the cost and provision of care. Despite significant efforts to collaborate using LICs and placing clients in Department custody, these issues are not being resolved on a consistent basis.

COOPERATION WITHIN THE DEPARTMENT

The individuals we spoke with expressed great enthusiasm about their initiative, but also vented frustration that other divisions within the Department did not embrace the same values, philosophy, and guidelines. This was interesting because, in fact, many of the same values and practices are being used among several divisions. When this was pointed out, the interviewees indicated that they did not understand what the other divisions were doing. This lack of information made it easy to dismiss or negate the efforts of other divisions. In addition, the frustrations expressed were most often toward other divisions of the Department and not usually at other partners such as education, the courts, or health. This is particularly problematic because three-quarters of the partners in communities are divisions of the Department of Human Services.

RECOMMENDATIONS

ESTABLISH DEPARTMENT PRACTICE PHILOSOPHY AND GUIDELINES

The Department, in conjunction with divisions and consumers, will develop a philosophy and set of guidelines for the delivery of services to clients and families. The guidelines will not supplant existing agency, program, or service standards but will provide a foundation and direction for successfully meeting the needs of clients and families, ensuring quality, and maintaining accountability and efficiency of scarce fiscal resources.

The overall emphasis of the guidelines is to promote and sustain a service delivery system that supports a client and family centered, strengths-based, culturally responsive, needs-driven planning process for creating individualized services and supports for clients and their families. This planning process should provide access to community based options, activities, natural supports, and services. The guidelines will also promote client/family decision-making at all levels and involve a partnership between the client, family, and agencies. Each element of the guidelines will be defined and explanations regarding how each is operationalized at the service delivery and administrative level will be provided.

IMPLEMENT THE PRACTICE PHILOSOPHY AND GUIDELINES

The divisions and consumers will work together to establish and implement a comprehensive and collaborative 5 year plan to operationalize the Department's guidelines. Rather than separately outlining the tasks and efforts of each division, the plan will be community focused and require all the divisions to work together to implement the guidelines in individual areas of the state. The plan will progressively bring on no more then 2 rural and 1 urban area each year. The first communities selected will be those where at least one division is actively and successfully using the philosophy of the guidelines. An assessment will be completed which will identify the additional technical assistance, training, resources, and mentoring needed to allow all the divisions in that community to operationalize the guidelines. These communities will be used as models for other communities. Each community, as they are brought in to implement the guidelines, will develop a plan that is tailored to the unique strengths, resources, and challenges of the area.

UTILIZE CHAMPIONS/CHEERLEADERS

A pool of supervisors, line workers, and administrators, who espouse the Department guidelines and philosophy in both their administrative and client based activities (the stuff is imprinted on their DNA), will be used to provide mentoring, modeling, problem solving, and reinforcing of the guidelines to local areas.

DEVELOP AND IMPLEMENT A SINGLE SERVICE PLAN

One of the founding goals of FACT was the development of a single comprehensive service plan for the client and family. The plan would incorporate the services and goals from all the agencies involved with the family. This goal has yet to be achieved. A parent advocate we interviewed expressed her frustration over having 5 different service plans for one of her children. She had separate plans from DSPD, mental health, DYC, DCFS, and the local school. She wondered why the Department of Human Services and its divisions, which represented 4 out of the 5 agencies, could not work together to develop one comprehensive service plan.

The divisions should work together to develop a format and process for a single service plan for clients who are receiving services from more than one division. This plan should incorporate all

players involved in the situation, formal and informal, so that the plan can be successful. The plan should address multiple domains in a person's life, and include a description of the need, highlight the strengths, and describe very specific goals, tasks, and activities. It should also define who is responsible for implementing each task, and who will fund the activity.

SHARE EFFECTIVE PRACTICES

Safety and Crisis Plans

Safety Plans and Crisis Plans are two tools that are being used effectively by Southwest Center to maintain severely emotional disturbed children in their rural communities. All children and families participating in the Frontiers Grant wraparound service model are involved in the development of a Crisis Plan. These plans often make it possible for clients to stay in their communities with family and supports, and allow high-cost care to be used primarily to stabilize situations. A Crisis Plan acknowledges that crisis can and will happen and plans for the reaction. It addresses behaviors and circumstances that would prevent a child from staying in a community placement. It also outlines the resources and supports the family would need to carry out the crisis plan. A crisis plan has three areas—predicting why/how a crisis will occur, what to do to prevent a crisis from occurring, and what to do if a crisis occurs. The goal is to help keep the client in the community and to minimize reactions that can occur that could cause a client to end up in a more restrictive setting. This tool should be used by DYC, DCFS, DSPD, DMH, DSA, and its providers to prevent placement disruption since many clients are returned to more restrictive settings or moved from their placement because of a crisis event.

Safety Plans are developed only for clients who are a safety risk to themselves or their communities. These plans are designed to clearly define the client's behaviors and actions that could result in harm to them or others, and outlines the steps to be taken to prevent and deal with these actions. This tool could also be valuable to other divisions.

Family/Client Involvement

DSPD has a long history of actively involving families and clients in every aspect of planning, implementing, and evaluating services and supports. They have promoted and supported the creation of client/family advocacy groups, and trained families and clients to be active participants in decision making at both the program and administrative level. The agency has piloted initiatives that have allowed families to determine, develop, access, and purchase services. As other divisions develop and support client/family organizations and empower clients and families, the experience and expertise of DSPD should be used as model for family involvement.

Cross Agency Initiatives

Because the Practice Model of DCFS and the Wraparound Model of DMH share many of the same values and principles, DCFS and DMH have forged a partnership to integrate the training curriculums of the two models. They are working to create one curriculum that can be used for training both mental health and child welfare workers. It is anticipated that the combined curriculum will be field tested at the two mental health Frontier Grant sites. The two agencies are also exploring ways to maximize the use of their paid training consultants and reduce duplication of effort.

APPENDIX

APPENDIX I

Descriptions of Initiatives Reviewed:

- **Wraparound – Mental Health**
- **Practice Model – Division of Child and Family Services**
- **Self Determination – Division of Services for People with Disabilities**
- **Dependency Court – Division's of Substance Abuse & Child and Family Services**
- **Archway Youth Service Center – Division of Youth Corrections**

WRAPAROUND -- MENTAL HEALTH

Background

In 1998, the Division of Mental Health received a grant from the Center for Mental Health Services (CMHS) to fund the Utah Rural Frontiers Project. The Frontiers Project is focused on developing a sustainable system of care for children and youth with severe emotional disturbance (SED) in the Frontier areas of Utah. The Frontiers Project focused on the wraparound technology to develop the system of care. They are operating on the premise that children belong to the community and that everyone in the community needs to be involved to assist them. Two cohorts are currently participating in the grant: Cohort 1 operates through the Southwest Mental Health Center (Beaver, Kane, and Garfield counties) and Cohort 2 operates through Four Corners Mental Health (Grand, Emery, and Carbon counties). Cohort 2 was brought in during the second year of the grant.

Definition

Wraparound is a way of working with children and families that involves the child and family in the planning process to determine a unique set of community-based services and natural supports individualized for that child and family. The planning process identifies the strengths of the child and family and determines needs across multiple settings including home, school, and community. Wraparound escalates the family role to a partnership role. Families receive training to ensure they are ready to take on this role.

Wraparound has been proven particularly useful for children with severe emotional and behavioral problems. It was developed to reduce the cost and reliance on expensive institutional care and to improve the fragmented system of care. The wraparound approach has been disseminated across the country as an effective way to address mental health needs more appropriately and effectively at the community level. It is also used effectively for early intervention as well as addressing more complex needs. Wraparound is currently used for people with a range of needs including young people, elderly, families impacted by cancer, and others.

Essential Elements

The successful implementation of wraparound involves the consistent use of a set of essential elements that include:

- Wraparound must be based in the community.
- Services and supports must be individualized, built on strengths, and meet the needs of children and families across life domains (e.g., living environment, financial, education/vocation, social/recreation, health/medical, behavioral/emotional) to promote success, safety, and permanence in home, school, and community.
- Families must be full and active partners in every level of the wraparound process.
- The wraparound plan is “needs-driven” versus “services-driven.” Children and families are not expected to fit existing services, but rather services are modified or new services developed to meet the needs of the child and family.
- The process must be culturally competent, building on the unique values, preferences, and strengths of children and families, and their communities.
- The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.
- Wraparound child and family teams must have adequate flexible approaches, and flexible funding.
- Wraparound plan must include a balance of formal services and informal community and family resources.

- An unconditional commitment to serve children and families is essential.
- The plan should be developed and implemented based on an interagency, community-based, collaborative process.
- Outcomes must be determined and measured for the system, for the program, and for the individual child and family.

Tools

All children/youth and families participating in the Frontiers Project participate in developing a wraparound plan and crisis plan. A wraparound plan includes all services to be provided to the child/youth, (e.g., the family, church, regional and local interagency councils, mental health, schools, medical professionals, juvenile court, DCFS). Goals and objectives for the child/youth are included in the plan as well as how the services will be provided, where they will be provided, who will provide them, and who will fund each service. For example, if the child/youth needs medical care, the type and frequency of care and the doctor are listed, and the family's medical insurance is listed as the mechanism for covering the cost.

The goal of the Crisis Plan is to keep clients in the community and to minimize reactions that can occur that could cause a client to end up in a more restrictive setting. The crisis plans often make it possible for clients to stay in their communities with family and supports, instead of moving to high-cost care. This allows high cost care to be used primarily to stabilize situations instead of long-term options. A Crisis Plan acknowledges that crisis can and will happen and plans for the reaction. It addresses behaviors and circumstances that would prevent a child from staying in a community placement. It also outlines the resources and supports the family would need to carry out the crisis plan. A crisis plan has three areas—predicting why/how a crisis will occur, what to do to prevent a crisis from occurring, and what to do if a crisis occurs.

Safety Plans are developed only for clients who are a safety risk to themselves or their communities. These plans are designed to clearly define the client's behaviors and actions that could result in harm to them or others, and outlines the steps to be taken to prevent and deal with these actions.

Training

Through the Frontiers Project, consultants (Vandenberg and Rast) were hired to provide overview trainings on wraparound to all frontier communities. This training provides front-line workers and families with a set of skills for effective collaboration and includes an extensive follow-up component. The goal is to ensure that after new material has been taught, staff go through guided practice with supervisors and mentors, then practice independently with additional follow-up.

Rast and Vandenberg try to look at where staff and families "get stuck" and provide skills to assist progress. They have reviewed a number of cases with Southwest Center staff and applied the wraparound model to demonstrate the differences in how a community can truly serve children.

The consultants' role in the Frontiers Project has expanded beyond training—they are currently reviewing the DCFS Practice Model and Wraparound technology and developing a crosswalk to determine where the two initiatives are consistent and where they differ. The goal is to develop a common curriculum that both divisions embrace and train, and also allow for discreet training elements that apply only to one division or the other. Currently, select people from each division are cross-training--attending the other division's training.

PRACTICE MODEL -- DIVISION OF CHILD AND FAMILY SERVICES

The Practice Model of the Division of Child and Family Services was designed to promote professional practice that is consistent with generally-accepted standards for quality child welfare services, and support the mission and guiding principles of DCFS though using the practice model principles and skills in daily practice. The model includes a set of principles that represent a philosophy about how best to assist children and families and a set of basic skills for the successful implementation of the practice principles.

Background

The Practice Model was initiated in January 2000. The Practice Model is the Division's "Operational Philosophy." The Practice Model is focused on ensuring that everyone who interacts with a family involved in DCFS comes with the same philosophy of service. The Practice Model philosophy can be characterized as strength-based, family-centered, and community-based. In addition, decisionmaking at all levels of the division reflects this philosophy.

The Practice Model provides a framework to guide workers while they are in the field. It is based on the premise that everyone in the Division needs a certain baseline set of skills, and the Practice Model is the mechanism to provide and develop these skills in its employees. According to Richard Anderson, "The goal is that practice will become so clear that people will know when they are not meeting practice." They will then change on their own with training. The Model provides a structure where staff members know that if they are following the principles and something fails, they will get credit for doing things the right way and the Division will support them.

The Practice Model focuses heavily on partnering and teaming with supports outside of the Division. The Division's goal is to ensure that the children and families are linked to their informal system—extended family, social clubs, church, and any other person/organization whom the family has personally involved in their family—to provide support to the family. This is where wraparound technology meets DCFS. Every family needs a team of informal and formal supports. The division works on developing the informal team and strengthens it for the long-term, so that the formal team can drop out. In developing and maintaining the team, the caseworker and team look at whether the right people are present; whether they are directly involved in the planning process, whether the goals and objectives of the service plan are monitored and implemented; and whether team members know their roles and are being held accountable for their roles.

The Practice Model is strength-based. When conducting functional assessments with clients, caseworkers are trained to look at the child and family's strengths—their culture, supports, personal strengths and history. A family's understanding of its problems is considered a strength. This approach provides a more balanced picture of the family and allows the family to move forward.

Practice Model Implementation

The Practice Model implementation process was designed to ensure that after each worker received the information regarding the Practice Model principles and skills through training, they had the opportunity to practice what they learned and receive feedback regarding their practice.

To begin the training process, the Division selected practice champions—those who were experienced in child welfare, really understood the practice model, believed in the principles, and wanted to help create change. The Division also believes it is necessary for front-line supervisors to initiate and sustain change. To facilitate this, the practice champions trained the

front-line supervisors who then trained their employees. The practice champions teamed with the supervisors while training staff to model the principles and show support. In response to regional concerns, the Division has provided more flexibility to regions in the way they train their supervisors and staff. Generally, supervisors help plan the training, then receive training from the practice champions with their staff. The Division is currently developing a formalized mentoring process to strengthen the application of training.

Practice Model Principles and Skills

The Practice Model principles and skills that Division staff are expected to support and practice are listed below:

Principles

- Protection: Children's safety is paramount; children and adults have a right to live free from abuse.
- Development: Children and families need consistent nurturing in a healthy environment to achieve their development potential.
- Permanency: All children need and are entitled to enduring relationships that provide a family, stability and belonging, and a sense of self that connects children to their past, present and future.
- Cultural Responsiveness: Children and families are to be understood within the context of their own family rules, traditions, history, and culture.
- Partnership: The entire community shares the responsibility to create an environment that helps families raise children to their fullest potential.
- Organizational Competence: Committed, qualified, trained, and skilled staff, supported by an effectively structured organization, help ensure positive outcomes for children and families.

Skills

- Engaging: The skill of effectively establishing a trusting relationship with children, parents, and essential individuals for the purpose of sustaining the work that is to be accomplished together.
- Teaming: The skill of assembling a team around children and families. The child and family team is chosen with the family and functions with the family's formal and informal supports to assess and plan. Child welfare is a community effort that requires a team.
- Assessing: The skill of working with the family to find the strengths and needs that must be addressed to resolve the issues that brought the family to the attention of the Division. Here we are determining the capability, willingness, and availability of resources for achieving safety, permanence and well being for the children.
- Planning: The skill of using assessment information to plan with the child and family team to create an individualized plan that addresses the family's strengths and needs and provides support for making changes. Service planning requires the planning cycle of assessing circumstances and resources, making decisions on directions to take, evaluating the effectiveness of the plan, reworking the plan as needed, celebrating successes, and facing consequences in response to lack of improvement.
- Intervening: The skill to intercede with actions that will decrease risk, provide for safety, promote permanence, and establish well being. These skills continue to be gathered throughout the life of the professional child welfare worker and may range from finding housing to changing a parent's pattern of thinking about their child. The primary intervention is to create a "wraparound" process for the family based on child and family team planning that supports a family long after the agency involvement is over.

SELF DETERMINATION -- DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

"Our goal is to supplement families, not supplant them."
Denise Winslow, Director, Self Determination Initiative.

Person Centered Planning and Budgeting

The Division of Services for People with Disabilities has implemented two major initiatives under Self Determination—person-centered planning and person-centered budgeting. These initiatives shift the power to determine what services are needed and provided by professionals and provider agencies to clients, their families, and support systems.

- Person-centered planning is a shift from professional and prescriptive planning to focusing on the client's desires and strengths. Clients determine the services they feel are best for them.

- Through person-centered budgeting, DSPD tells the client how much money they have available, the client notifies DSPD regarding the services/service providers they would like to use, and DSPD purchases the services. DSPD has found that clients make cost-effective service decisions because they want to make the best use of their funds.

This new budget focus has changed the way DSPD works with its providers. Ten years ago, prior to person-centered budgeting, DSPD purchased "slots" with providers in closed-ended contracts. DSPD now uses open-ended contracts—funding people instead of programs and facilities. Now with self-determination each person/family who receives services from the Division also knows how much is being spent to provide those services. This has provided clients with much more service flexibility, but has made providers a little uncomfortable because they can no longer count on "lump-sum" amounts of money.

The coordinator for the Self Determination initiative focused heavily on the following: Self determination is all about who has the authority over the money. If clients have authority over the funds available to them, they have power over the services they buy, creating greater self-determination.

Pilot Projects

To further increase client control over services, DSPD is piloting two additional programs—Self-Directed Supports and Microboards.

- Self-Directed Supports allow the client and their families to become the direct employers of support staff for traditional services such as supported employment, day services, and supported living. They can recruit, employ, and supervise staff without using a provider agency. The client uses a small percentage of their money to purchase fiscal agent services to cover the payroll activities such as collecting time sheets, withholding taxes, preparing paychecks, etc. This option expands the available workforce for people with disabilities to include friends, neighbors, and relatives to provide needed supports. Each family that participates in this option must develop an extensive person-centered plan that provides details on measurable outcomes, support strategies, natural supports, budget, and barriers to the plan. The Division Leadership Team must approve the plan before a family can join the pilot. The pilot currently has about 20 families.

- Microboards allow an individual, family, and friends to incorporate as a non-profit provider. These Boards are designed to get family and friends involved on a long-term basis in the life and supports of a person with developmental disabilities. The group incorporates as a

business to operate under contract with DSPD. The Microboard must include five people, some family and some friends. The Boards are typically set up to serve one person. This allows a family to provide services with support from DSPD. This option requires a significant time and energy commitment from the Board and Board members cannot be paid.

With these additional service options, DSPD provides the following full continuum of flexibility to its clients:

Full Service Provider----------→**Self Directed Supports**----------→**MicroBoards**
With self-directed planning and budgeting — Client/family takes full charge

Service Broker

DSPD is also implementing a Service Broker model. The Service Broker typically works independently to help people on the waitlist and those in services to review the services desired and provide a wide array of options from which the person can choose. The division implemented a three-month Service Broker program to assist those on the waitlist to find services in the community. This Broker had no access to division funding and only helped people to identify and use their current resources or to access other non-Division services. A study of this program found that the Service Broker helped reduce the level of stress and frustration felt by the families and increased their knowledge of the community resources and their ability to access these services. They found a number of resources people with disabilities can access outside of paid division supports. Because this initiative was so successful, the division plans to include Service Brokers as one of the services clients can access with their funds to assist them in finding additional community services.

Family and Consumer Councils

To ensure families are truly involved in DSPD planning and training, DSPD has implemented state, regional, and local family councils and consumer councils. Currently, across the state, there are 22 family councils (including a Spanish speaking council) and 7 consumer councils. Consumer councils are made up of people receiving division services. They develop an advocacy role and provide input into the direction the division should take when developing new supports for their clients. Family councils provide support to families on the wait-list, and provide an introduction and training to new families entering the DSPD system. The state councils help local areas form local councils. The Division provides transportation, respite care, staffing, and funding if needed.

Self-Advocacy Network

To support those with disabilities to actively participate in policy making, DSPD has initiated The Utah Advocacy Network. This network will provide ongoing support to citizens with disabilities throughout the state. Through the network's training and support Utahn's with disabilities can gain the skills needed to advocate for themselves and their peers. Partners in this Network include Disability Law Center, USU Center for People with Disabilities, Utah Department of Education, Governor's Council for People with Disabilities, and The Arc.

DEPENDENCY COURT -- DIVISIONS OF SUBSTANCE ABUSE & CHILD AND FAMILY SERVICES

The Dependency Court focuses on people with substance abuse problems who are involved with the Division of Child and Family Services. Dependency Court clients are working to either maintain their child(ren) in their home, or working to have their child(ren) returned home from an out-of-home placement. In Dependency Court (similar to Drug Court), people with substance abuse problems attend court, receive substance abuse treatment, and work to remain clean. If they fail to meet the Dependency Court program requirements, they return to the traditional juvenile justice system.

The Dependency Court client works through three phases, each lasting 3-6 months. Each phase has a set of assignments, which include completing random urinalysis, staying clean for three months, weekly contact with caseworker, and attending substance abuse treatment. The final phase reduces the frequency of appearing in front of the Court, but requires the person to obtain a GED or be gainfully employed and have stable housing for three months. Upon completing the three phases, the client graduates from the program.

The Dependency Court operating in Utah County demonstrates the concept of true teamwork across a number of agencies. After learning about the Dependency Court concept, Judge Kay Lindsey approached the Divisions of Child and Family Services (DCFS) and Substance Abuse (DSA), the Attorney General's Office (AG) and the Guardian Ad Litem (GAL). DCFS agreed to dedicate a half-time coordinator and DSA agreed to provide the drug testing and a coordinator. The Judge and representatives from each agency developed the program together, attended a national training, and currently meet monthly for brown-bag training lunches. The Judge credits the enthusiasm for the program to the fact that all parties bought into the idea at the beginning and have participated in making the program successful.

The Dependency Court meets twice per month. The Judge, caseworkers for the clients, the Dependency Court coordinator, AG's office, GAL, Public Defender, Utah County Substance Abuse representative, and a peer parent meet to staff the cases. DCFS caseworkers provide write-ups of their client's status and their compliance with the Dependency Court rules. The group then discusses the progress and needs of each case and determine a course of action. The goal is to provide positive support for the clients to help them either become or remain substance-free, but also to implement fair sanctions if a client is not following the rules of the court. For instance, if a client does not provide a urinalysis when required, or the urinalysis has been tampered with, the client spends a night in jail. The Court works on ensuring sanctions are consistent across clients, but try to take into consideration the client's circumstances. The Court works very closely with Utah County Substance Abuse to find treatment opportunities for the clients. The treatment centers are cooperative when asked to hold spaces open in treatment facilities until a client completes jail time or other treatment.

The Dependency Court focuses on the positive with each client. They congratulate each client for their successes and help them think through why negatives may have happened. Even when a client has broken a number of the court rules, the Judge talks about how a stay in the jail will give them a time to think, and to provide a positive new start.

ARCHWAY YOUTH SERVICE CENTER -- DIVISION OF YOUTH CORRECTIONS

In Weber County, the Division of Child and Family Services has contracted Youth Services to the Division of Youth Correction's Archway program. DYC sees this as an opportunity to provide early intervention and prevention to the area's youth.

Archway provides Youth Services in Ogden. Archway is not a punitive facility. It is a structured, non-secure, voluntary place for youth and their families to get assistance. Archway provides three main services:

- Receiving Center—A non-secure drop off point for youth who do not meet admission guidelines to detention; whose parents cannot be contacted or refuse custody; and/or youth who are in need of a temporary placement due to run-away, homelessness, or are ungovernable.
- Community Services—Programming focuses on family support, parenting courses, crisis intervention, treatment groups, and individual and family counseling. Archway staff go into a youth's home (on request) to work with the youth, parents, and other children in the home. They focus on developing and improving family communication, conflict resolution skills, and general problemsolving skills. Counselors often complete a behavior contract with the family, give ideas regarding how the family can work together, and make referrals to Mental Health if needed. Each family is allowed up to 60 days of services. The average time for case closure is 48 days. Every family is staffed each week.
- Residential Unit—A 24-bed facility, available for transition and crisis, that provides school, recreation, and therapeutic programming. Youth have been referred to this facility by a parent, Weber Human Services, schools, or youths themselves who does not want to live at home. Archway can help this population find an independent living situation.

The Archway Director feels the Community Service piece is very important. "It provides a great opportunity to provide crisis counseling when parents are frustrated. We give little ideas and do contracts between family members." Parents see the services as a way to get help at home and a place to call when things are bad. Archway also offers a wide variety of voluntary training opportunities to youth and their families. Topics include anger management, theft reform, Love & Logic, and self-esteem. These courses, particularly Love & Logic, are well attended. Archway runs groups in schools around social skills and anger management for youth referred from school counselors. If Archway staff see a youth with major issues, they will add them to their caseload and provide additional services.

Archway partners with many community organizations including DCFS, DMH, schools, community action programs, family support centers, and law enforcement. The Archway Director says Mental Health is very supportive of the program. When a youth has mental health issues, a representative from Weber Mental Health will assess the youth with little waiting 24 hours per day.

Archway staff are continuously in training. The director, supervisors, and others from Weber Human Services provide inservice trainings, trainings at staff meetings and during reviews, and through individual shadowing. This ensures all staff have the most current knowledge about working with the clients and in the community.

APPENDIX

APPENDIX II

Examples of Tools:

- **Strength Versus Deficit Approach**
- **Wraparound Plan**
- **Safety Plan**